Public Employees Benefits Board (PEBB)

2007 COBRA Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate dependent certification forms if required (students age 20-23, extended dependents, and disabled dependents.) Forms are available at **www.pebb.hca.wa.gov.**

Employee/Retiree Information ONLY	Employee/retiree name	
	Employee/retiree social security number	Date employer or retiree coverage ended (mm/dd/yyyy)

I/we elect COBRA continuation coverage as indicated below:

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ☐ M ☐ F	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)		

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code. ➡ Physician or clinic code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **send a copy** of your Social Security Disability Award letter along with this form.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, **send a copy** of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ☐ Yes ☐ No Effective date _____

Section 2: SPOUSE INFORMATION

*List **only** eligible family members.*

Social security number	Date of marriage (mm/dd/yyyy)	Physician or clinic code	Sex ☐ M ☐ F
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason** **Date of event**

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **send a copy** of your Social Security Disability Award letter along with this form.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, **send a copy** of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ☐ Yes ☐ No Effective date _____

Section 3: FAMILY MEMBER INFORMATION *Use additional forms for more members. List only eligible family members.*

A

Relationship to subscriber	Social security number	Physician or clinic code	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Sex ☐ M ☐ F

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason** _____ **Date of event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **send a copy** of your Social Security Disability Award letter along with this form.

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, **send a copy** of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ☐ Yes ☐ No Effective date _____

B

Relationship to subscriber	Social security number	Physician or clinic code	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Sex ☐ M ☐ F

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason** _____ **Date of event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **send a copy** of your Social Security Disability Award letter along with this form.

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, **send a copy** of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ☐ Yes ☐ No Effective date _____

Section 4: MEDICAL PLAN SELECTION
(Check only one.)

- ☐ Community Health Plan Classic
- ☐ Group Health Classic
- ☐ Group Health Value
- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Value
- ☐ Medicare Supplement Plan E, administered by Premera Blue Cross (Medicare enrollees only)
- ☐ Medicare Supplement Plan J administered by Premera Blue Cross (Medicare enrollees only)
- ☐ Secure Horizons Classic* (Medicare enrollees only)
- ☐ Secure Horizons Value* (Medicare enrollees only)
- ☐ Regence Classic*
- ☐ Uniform Medical Plan

** These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.*

Section 5: DENTAL PLAN SELECTION
(Check only one.)

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: SIGNATURE (Required)

I/we have received and read this entire *Continuation of Coverage Election Notice* including any appendices. I/we understand that insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that, to the best of my knowledge and belief, my family member and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information I submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Signature _____ Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Visit our Web site at www.pebb.hca.wa.gov

Please sign and date this form.

Return to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

If payment enclosed, return to:
Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

For Agency Use Only ❑ 18-month (Terminated or reduction in hours) ❑ 29-month (Approved disability [SSI]) ❑ 36-month (Spouse/child: loss of dependent eligibility)